PARAGON
Health Partners

PARAGON PAIN REHABILITATION, LLP

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient's name: _____ Prior Name, if any: _____
Address: _____ Phone Number: _____
City: _____ State: _____ Zip Code: _____ DOB: _____

RECEIVING PARTY: I hereby authorize Paragon Pain Rehabilitation, LLP ("Paragon") to release my health information, including copies of my medical records, to the following person or entity:

_____
Name of Person or Entity Telephone No

.

_____
Street City State Zip

PURPOSE OF RELEASE:

☐ Medical Care ☐ Legal ☐ Insurance ☐ Personal Copy ☐ Leaving Paragon*
☐ Other

TYPE OF INFORMATION TO BE RELEASED (Please indicate by checking applicable box):	**SPECIFIC INFORMATION TO BE RELEASED (Please confirm release by initialing below):**
☐ Complete medical record (Please specify dates of service): _____ ☐ Partial Medical record (Please specify which records): _____ ☐ Billing Records ☐ Other	_____ HIV/AIDS/STD test results/information _____ Genetic testing information _____ Alcohol/Drug Abuse _____ Behavioral/Mental Health Information

1. **EXPIRATION OF AUTHORIZATION:** I understand that this Authorization is valid for three (3) years from the date I sign this authorization and will expire at that time unless another expiration date/event is written here: _____.

2. **SPECIAL INFORMATION**: This authorization may include disclosure of information relating to **DRUG**, **ALCOHOL** and **SUBSTANCE ABUSE**, **MENTAL HEALTH INFORMATION**, except psychotherapy notes, **CONFIDENTIAL HIV/AIDS-RELATED INFORMATION**, and **GENETIC INFORMATION** only if I place my initials on the appropriate lines above. In the event the health information described above includes any of these types of information, and I initial the corresponding lines in the box above, I specifically authorize release of such information to the person or entity indicated herein.

3. **RIGHT TO REVOKE AUTHORIZATION**: I understand that I have the right to revoke this authorization at any time by giving written notification to Paragon at info@paragonphp.com. I understand that the revocation will not have any effect on actions taken by Paragon in reliance on this authorization before it receives my written notice of revocation. I also understand that the revocation will not apply to any health information that has already been released in response to this authorization. Once Paragon has released my health information to a recipient, the recipient may re-disclose my health information to third parties.

4. **RIGHT TO REFUSE TO SIGN AUTHORIZATION**: I understand that I may refuse to sign this authorization. I understand that my refusal will not affect my ability to receive treatment at Paragon and that Paragon may not condition treatment, payment, enrollment or eligibility benefits on whether or not I sign the authorization.

5. **RIGHT TO COPY OF AUTHORIZATION**: I understand that I have a right to a signed copy of this authorization.

By signing below, I understand the potential that medical records and information disclosed pursuant to this authorization in whatever form and/or means provided may be subject to re-disclosure by the recipient and will no longer be subject to protections under the federal privacy laws and regulations. I hereby release Paragon and its agents and employees from any and all liabilities, responsibilities, damages, and claims which might arise from the release, receipt, and/or re-disclosure of these medical records and the information included I have authorized above.

_____ _____

Signature of Patient (or Patient's representative) Date

_____ _____

Printed Name If Representative, Basis for Authority

If the patient is minor, the minor individual's signature is also required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment.

Signature of Minor (if applicable): _____

Date: _____